Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL240539025M
Compliance #: HL240536552C

Date Concluded: June 13, 2024

Name, Address, and County of Licensee Investigated:
Ability Holdings (Prairie Meadows)
800 5th Avenue Northwest
Kasson, MN 55944
Dodge County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Danyell Eccleston, RN, Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when the resident laid on the floor for approximately nine hours before emergency services was contacted and took the resident to the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility left the resident lying on the floor for approximately nine hours before emergency services were contacted. The resident was soaked in urine when the ambulance crew arrived. The resident was taken to the hospital and treated for rhabdomyolysis (injury that causes muscles to break down and release toxic components into the blood and kidneys).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted ambulance services and the police department. The investigation included review of resident medical records, staff

schedules, law enforcement report, emergency medical response report, and related facility policies and procedures. Also, the investigator observed staff members providing care to residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease with behavioral changes. The resident's service plan included safety and "I'm okay" checks and assistance with bladder incontinence as needed. The resident's assessment indicated the resident was easily distracted, had periods of altered perception or awareness of surroundings, varied mental function during the day, and was resistive to cares.

Review of progress notes from late morning the day of the incident indicated staff informed the on-call nurse the resident put himself on the floor and refused to get up from the floor or change position. The note indicated the resident had a history of aggressive behavior and although he was on the floor, he was not in any danger. The nurse advised staff to let him lay on the floor and check the resident frequently. Progress notes approximately an hour and a half later indicated the resident was still lying on the floor and went from responding to minimally to not responding to staff. Progress notes approximately five hours later indicated the resident was still on the floor. Further notes indicated a family member reported to the nurse the resident had not eaten all day, refused cares, refused to let the family member help, and had not taken any prescribed medication that helped with aggression. The family member desired to have the resident evaluated and the nurse instructed staff to call 9-1-1.

Review of ambulance records indicated staff informed emergency response the resident was lying on the floor for nine hours and did not receive daily medication, eat, or drink anything during the time he was on the floor. The resident was responsive to pain and saturated with urine. No obvious signs of injury were noted.

Review of hospital records indicated the resident admitted to the hospital with rhabdomyolysis after laying on the floor for several hours.

During interview, an unlicensed staff member, who was assigned to the resident during the day in question, stated she did not see the resident get on the floor during the morning hours, but assumed he purposely laid down on the floor of his room due to his behavior history. The unlicensed personnel assumed the resident did not have an injury and did not contact the nurse.

During interview, a second unlicensed staff member stated she worked in the assisted living area of the facility during the day in question and the unlicensed staff member assigned to the memory care unit asked her to come see the resident. The resident was laying down face first on the floor, breathing and mumbling, and had mucus coming out of his nose. The second unlicensed staff member stated the resident's feet were "freezing" so she put socks on the resident and put a pillow with the resident. The second unlicensed staff member contacted the on-call nurse for advisement and was instructed to keep checking up on the resident.

During interview, the on-call nurse stated she received a call midday indicating the resident put himself purposely on the floor and refused to get up. The nurse stated she would not want a resident to lay on the floor for a long period of time and was told the resident was checked on, had no injury, and was refusing to get up. The nurse stated she contacted facility leadership and a family member of the resident.

During interview, the resident's family member stated she received a phone call in the afternoon that the resident had been lying on the floor since the morning. The family member went to the facility and stated she was "horrified" when she saw the resident. The resident was wet with urine and was not having any reactions, the family member stated she was the one who called 9-1-1.

During interview, an emergency response personnel stated when he arrived at the facility, the resident was laying on hard laminate floor and was soaked in urine from the bottom of his rib cage and down his pants. Staff informed emergency response personnel the resident was laying on the floor for eight to nine hours and had not eaten. Emergency response rolled the resident and lifted him to a stretcher for transportation to the hospital.

During interview, a police officer stated the resident was lying on the floor and trembling when he arrived at the facility. The officer stated he spoke with staff and the unlicensed personnel assigned to the resident indicated she did not call 9-1-1 because she was too busy, and another personnel member indicated he was instructed not to contact emergency services.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, resident deceased.
Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Facility conducted an internal review of the incident.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Dodge County Attorney
Kasson City Attorney
Kasson Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24053	A. BUILDING: _____ B. WING _____	C 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADOW) LLC	800 5TH AVE NW KASSON, MN 55944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL240536552C/#HL240539025M #HL240538953C/#HL240531401M On March 19, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 56 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL240536552C/#HL240539025M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABILIT HOLDINGS (PRAIRIE MEADO	800 5TH AVE NW KASSON, MN 55944

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	